Request for Special Accommodation in GED Test Administration for Candidates with Physical or Emotional Disabilities

To: GED Administrator

EXAMINER

CENTER ID NUMBER	CHIEF EXAMINER	DATE

CENTER NAME

ADDRESS

CITY	JURISDICTION	ZIP/POSTAL CODE

TELEPHONE NUMBER	FAX NUMBER	PROPOSED TESTING DATE

GED CANDIDATE

CANDIDATE NAME	SOCIAL SECURITY/SOCIAL INSURANCE NUMBER

ADDRESS

CITY	JURISDICTION	ZIP/POSTAL CODE

TELEPHONE NUMBER	E-MAIL ADDRESS	DATE OF BIRTH

I grant permission for the release of my medical or psychological records to verify this accommodations request.

CANDIDATE'S SIGNATURE | GUARDIAN'S SIGNATURE (IF APPLICABLE) | DATE

CERTIFYING PROFESSIONAL

I. Certifying Professional: I certify that I am licensed to diagnose and treat the disability specified below:

NAME OF CERTIFYING PROFESSIONAL (TYPE OR PRINT)	SIGNATURE:

DATE	TELEPHONE NUMBER	FAX NUMBER	E-MAIL ADDRESS

LICENSE TYPE:	LICENSE NUMBER:

II. Basis for Request: Define condition(s) that make modification to standard testing procedure necessary and describe the modification(s) that you propose. Attach any supporting documents. Continue on back of page if necessary.

A: Condition

VISUAL IMPAIRMENT — DESCRIBE:	HEARING IMPAIRMENT — DESCRIBE:

MOBILITY IMPAIRMENT — DESCRIBE:	DSM IV CODE:

OTHER — DESCRIBE:

B: Modification

- ○ EXTENDED TIME: _____ (specify; i.e., 1.5x, 2x, etc.)
- ○ BRAILLE EDITION
- ○ CALCULATOR/TALKING CALCULATOR
- ○ INSTRUCTIONS INTERPRETED FOR DEAF CANDIDATE
- ○ OTHER: DESCRIBE BELOW:
- ○ LARGE PRINT EDITION
- ○ AUDIOCASSETTE EDITION
- ○ PRINTED TEST INSTRUCTIONS
- ○ SUPERVISED FREQUENT BREAKS
- ○ OFF-SITE TESTING: DESCRIBE BELOW:
- ○ PRIVATE ROOM
- ○ SCRIBE

GED USE ONLY

IV. Approval by State, Provincial, or Territorial GED Administrator

○ APPROVED ○ NOT APPROVED FOR:	SIGNATURE, GED ADMINISTRATOR	DATE

Request for Special Testing: Candidates with Physical Disabilities

Date: _____

Regarding: _____

CERTIFYING PROFESSIONAL